SOUTHWESTERN VIRGINIA TRAINING CENTER
October 8-9, 2004
OIG Report#105-04

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at Southwestern Virginia Training Center in Hillsville, Virginia during October 8-9, 2004. The inspection focused on a review of the facility through the application of thirty-two (32) quality statements divided over five (5) domains. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the five training center facility directors, parents and advocacy groups, DMHMRSAS central office administrative staff, DMHMRSAS Office of Mental Retardation Services staff and directors of mental retardation services for community services boards. The quality statements address the facility's mission and values, access to services, service provision, facility operations and community relationships. The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into five primary sections focusing on each of the domains.

SOURCES OF INFORMATION: Interviews were conducted with thirty-one (31) members of the staff including administrative, clinical and direct care staff. Documentation review included, but were not limited to: four (4) clinical records, individualized habilitation plans and behavioral support plans, selected policies and procedures, staff training curriculums, facility quality management plans, survey materials and performance improvement initiatives. Tours were conducted in selected residential and programming areas.

MISSION AND VALUES

1. The facility has a clear mission statement.

Interviews were completed with thirty-one (31) members of the staff including administrative, clinical and direct care staff. Administrative staff revealed that the facility's Quality Improvement Council conducted its annual review of the facility's goals during the Summer 2004. The Quality Improvement Council used the DMHMRSAS vision statement as the foundation for revising the facility's vision statement. The facility director emphasized the new vision statement in a recent employee newsletter asking all employees to reflect on the recent changes and provide input on ways to effectively address the goals and objectives established. Staff interviewed were well versed in the new vision statement.

The mission statement for the facility is "to provide the best possible residential and habilitative service for citizens of southwest Virginia with mental retardation". Other staff comments regarding the facility's mission included these statements: to meet the service needs of the developmentally disabled; to assist residents gain the necessary skills to reside in a less restrictive environment; and to assure that the residents are healthy, safe and receive the services necessary for them to lead productive and meaningful lives.

2. The facility has a clear philosophy and set of values to guide how the staff will carry out their work, how the staff will relate to the consumers and how the staff will relate to each other.

The majority (28) of the staff members interviewed indicated that the facility applies the "Golden Rule" in guiding the staff in understanding the values associated with carrying out their duties and relating to others in the environment. It was indicated that staff throughout their pre-service training and in the day-to-day operations of the facility are reminded of the importance of treating each person with dignity and respect. One other value emphasized, according to those interviewed, is that the residents come first. During the tours of the facility, staff were observed relating to the residents in a relaxed, respectful and friendly manner. Staff spoke with pride regarding the residents and, as appropriate, included them in the discussions.

Nine (9) of the staff members interviewed indicated that there is a sense of family within the facility. They related that the facility director visits the units daily, asking how things are going and being open for suggestions, comments or concerns. They indicated that they are always amazed that he knows each resident and each staff member by name.

ACCESS/ADMISSIONS:

1. Policies and Procedures that govern admission are consistent with the facility's mission statement.

The team reviewed the facility's policy (SWVTC Instruction 410) regarding admissions and found it consistent with the facility's mission statement. The policy outlines the process for securing the necessary information from the community for determining whether the facility is the best setting for meeting the identified needs of the applicant. Staff indicated that it has always been the approach of SWVTC to ask, "Why would we not take this person instead of why would we." It was suggested that this subtle shift in perspective required staff to focus more on how the admission would affect the person instead of how it would affect the facility.

2. Admission to the facility is based on a thorough assessment of each resident's needs and level of functioning.

Interviews with five administrative and clinical staff members, a review of four resident records, and review of facility policy revealed that the facility's admission process is based on a thorough assessment of each applicant's needs and level of functioning.

Each potential applicant submits an admission packet through the referring community services board. It is the responsibility of the Community Services Director at the facility to assure that an appropriate team of facility staff reviews the packet of information. Facility social workers conduct home visits in order to gain additional information regarding the applicant and to serve as a resource for families or other responsible

persons during this time of transition. The assigned social worker makes a case presentation to the Admissions Committee, which makes recommendations to the director. The director then has thirty days by which to relay the decision to the applicant and the CSB. Interviews revealed that once the person is admitted to the facility, initial assessments are conducted in order to begin the process of developing the person's individualized habilitation plan.

Nine scheduled admissions were completed at this facility during the period from 7/1/03 to 7/1/04. The team was informed that an additional five people were accepted for admissions but they are currently on a waiting list for an available bed.

The admission process to the Pathways Program is the same except a regional board makes the final determination regarding admissions to that program, not just the facility director. This regional program is designed to address the often-challenging training and behavioral issues of the dually diagnosed (MH/MR) population.

3. The facility has a mechanism in place for addressing emergency admissions.

Interviews revealed that emergency admissions are handled in the same manner as those seeking regular admissions but that the facility does not require all of the community assessments to have been completed prior to review of the case. This is because of the emergent nature of the requests. Basic information regarding the person's status, including any medical and behavioral healthcare needs, is required prior to admission. The facility also reviews possible ways of aiding the person to remain in the community through the development of additional supports. Facility staff are available to provide the consultation necessary to support this goal. During the last fiscal year there were 26 requests for emergency admission and 3 of those were admitted. Interviews revealed that SWVTC makes every effort to assist the community with their consumers during times of emergencies. It was indicated that the facility received a number of requests from community providers outside of the region for emergency admission to the dually diagnosed (MR/MI) program on campus but that admission to that service has been limited to persons within the region.

SERVICE PROVISION / CONSUMER ACTIVITIES

1. Activities are designed to facilitate socialization, skills acquisition and community integration.

Four (4) resident records were reviewed. All provided evidence that the individualized habilitation plans were designed to address skills acquisition, facilitate socialization and provide for opportunities for community integration.

During the inspection, the team observed active day programming, prevocational programming and vocational services. In the vocational programming in Building 10 there were eight residents present with one staff and a regular volunteer. The work being performed included: paper shredding, crushing cans, and the washing and drying of a

variety of items. The space was functional and appropriate for the work being completed. It was noted that the interaction between the staff and residents was very positive. Staff encouraged and supported the residents in accomplishing their tasks.

In the prevocational classroom within the same building, there were 8 residents and 2 staff members. The staff were assisting the residents in staying focused and on task. All but one resident was actively engaged. The tasks were designed to assist the residents in sorting and matching shapes.

Observations were also made of the scheduled active day programming located in the gym. Residents were engaged in a number of activities including a music group, a speech therapy group, recreational activities and sensory stimulation opportunities.

2. Residents are actively engaged.

Overall observations and interviews revealed that staff actively engaged the residents in the programming. The facility offers a full array of activities for residents to engage in throughout the day and early evening.

During the morning tours of several of the cottages, it was noted that the residents were preparing for the day. They were having breakfast, attending to their activities of daily living and engaging with staff. One cottage has a "walking" group that makes strolling around the campus a part of the morning routine. Three residents in that unit specifically approached the team member to indicate that they really enjoyed this activity.

3. Activities occur as scheduled.

Interviews and observations revealed that the activities were occurring as scheduled. Activities were occurring as planned in both the day programming areas and on the residential units.

4. Residents are supported in participating in off-grounds activities.

Interviews with staff revealed that the residents have many opportunities to participate in individual and small group activities in the community such as going shopping, to ball games, on picnics and to the movies.

5. The facility provides adequate outreach and discharge planning services to facilitate the resident's transition to the community.

Interviews with four members of the administrative and clinical staff indicated that transition planning begins at the time of admission. Most of the coordination with community placement is completed by the five (5) social workers. The social workers are not assigned a particular caseload but rather are assigned to specific community services boards. This approach has served to foster good working relationships between the

facility and the referring boards. The facility assists the residents in making as smooth a transition as possible through frequent trial visits and staff to staff interactions.

FACILITY OPERATIONS / SAFE ENVIRONMENT

1. The safety and security of the residential units are assessed, risk factors are identified and changes are implemented in a timely manner.

Interviews revealed that the safety and security of the residents is considered one of the most important functions of the facility. As a result there are a number of safety and security measures in place. Buildings and Grounds staff conduct monthly safety inspections in all of the buildings. This is coupled with routine inspections completed in each residential area by the unit manager. Unit staff interviewed indicated that the staff in buildings and grounds are very responsive when called regarding anything that needs to be fixed within the facility. All indicated that work orders that pose a safety risk to either staff or residents are prioritized.

In addition, the facility conducts routine fire and medical emergency drills. Fire drills are done monthly so that one is completed on each shift quarterly. As weather permits, residents are evacuated during the drills so that the facility has an accurate assessment of the time it would take to successfully vacate the buildings.

SWVTC has five safety and security officers who provide around the clock security services on campus. The officers patrol the campus and conduct security checks on the buildings, particularly during the evening and nighttime shifts. The officers also help with transporting residents in the evening as appropriate.

2. There are adequate safeguards to protect residents from abuse and neglect.

Interviews revealed that the safeguards for protecting the residents from abuse and neglect start at the hiring process with the initiation of background checks. Staff are introduced to human rights and the procedures for reporting abuse and neglect during their initial pre-service training. Staff are provided with case scenarios for discussion to assure that they are able to apply the principles and procedures they are learning. Annual re-training for both human rights and reporting abuse and neglect is required.

Staff (10 interviewed) indicated that one of the safeguards for protecting the residents is the awareness that supervisory staff and/or the facility director could enter any unit at anytime, including the evenings and the weekends. The direct care staff interviewed indicated that because of the length of time most staff have worked at the facility that they consider the residents “members of the family”. As such, they related that they would not hesitate to contact the facility director if they witnessed the abuse of a resident.

Another mechanism identified was the event reporting system, which allows for an administrative review of an incident that is unexplained or suspicious without the presence of a specific allegation. Interviews with administrative staff indicated that it is

the goal of the facility to conduct investigations in such a manner as to maximize the learning opportunities for the staff instead of it being a "gotcha" process. Two members of the facility's police force are trained abuse and neglect investigators. All those interviewed indicated that they had confidence that the investigators would perform their duties in a confidential and professional manner. There were 44 allegations of abuse and neglect made at this facility during the first six months of 2004. None of the allegations were substantiated.

3. There are adequate safeguards to protect residents from critical and/or life threatening incidents.

The risk manager tracks critical incidents. There were approximately 40 critical incidents reported to VOPA and the OIG from January to September 2004. Each of these are reviewed by the facility director, human rights advocate and quality assurance officer within the facility. The risk manger looks for trends in the data by conducting routine reviews to determine not only what events are occurring but also when and where the events take place. For example, in reviewing the incidents reports it was noted that there had been several injuries to residents on the swings. This information was communicated to buildings and grounds staff, who conducted safety checks on all the swings on campus. It was noted during the checks that several of the swing chains had become loosened due to their frequent usage, which could result in scratches, catching the resident's clothing or potential falls due to breakage. Maintenance staff replaced the chains with heavier ones that had additional safety latches to prevent possible risk to the residents.

The risk management and residents safety committees also review the aggregate data during their regularly scheduled meetings. When concerns are identified, plans of action are developed and followed until resolved. There were 160 incidents of peer-to-peer aggression reported at the facility during the first two quarters of 2004. Eighty-two of the incidents resulted in minor injuries to one or both of the residents involved. In each case, strategies were developed to lessen the likelihood of a reoccurrence.

Interviews with medical and nursing personnel revealed that the facility's on-going and routine review of the residents' healthcare status is an additional safeguard for protecting the residents from critical and/or life threatening events. The facility completes many preventative health checks on the residents. It was also noted that staff, in general, serve to protect the residents from life threatening incidents. It was reported that staff feel comfortable reporting any concerns regarding a resident to either the medical director or nurse practitioner.

4. Restrictive procedures are used in accordance with facility policies and procedures. Their use is clearly documented and is carefully monitored.

Interviews with 12 administrative and direct care staff, a review of 2 records with behavioral plans and a review of the behavioral management policy (SWVTC Instruction 570) indicated that the facility implements restrictive procedures in accordance with the policy.

As with the other facilities in the state system, staff are trained in the Therapeutic Options for Virginia (TOVA) model, which focuses on developing effective working relationships. It also provides staff with a greater understanding on how to effectively apply behavioral management strategies. Interviews with supervisory staff revealed that a large percentage of the direct care staff have indicated that this approach is easier to understand and better than previously used training materials. One of the goals of the TOVA training, according to direct care staff, is the reduction of behavioral management plans that have restrictive procedures. The facility data indicated that there are approximately 160 residents with behavioral management plans, 54 of which involve procedures that require approval by the local human rights committee. The facility tracks the use of restrictive procedures and uses the information for case review, as well as for providing additional training opportunities when appropriate.

SWVTC currently has less than five individuals with a behavioral management plan that has isolated time-out as an approved intervention. However, administrative staff related that this technique is almost never used even when it is an option.

Isolated timeout is defined as "the removal of a client from ongoing reinforcement to a specifically designated time-out room." SWVTC complies with CMS regulations, which outline the circumstances under which ICF/MR facilities can use the time-out room. These include:

- The use of the time-out room has to be a part of an approved systemic time-out program.
- The use of the time-out room can not be used as an emergency intervention,
- The client is under direct constant visual supervision while in the time-out room
- The door to the time out room is held shut by staff or by a mechanism requiring pressure from staff

5. Residents and their legally authorized representatives are informed of their rights and have a mechanism for making complaints and grievances. These are addressed in a timely manner.

Human Rights training is provided for all staff at the time of their orientation and annually thereafter. Residents and their legally authorized representatives are advised of the human rights process at the time of admission and at least annually. Documentation of this is located in the resident's record.

The facility has both an informal and formal process for handling complaints. The facility director handles informal complaints, as is the procedure with the other training centers. It was noted that the facility handled 9 informal complaints and addressed 9 formal complaints during the first six months of 2004.

Notifications of the resident's rights and the complaint process were located in the resident records reviewed.

6. Medication usage is appropriately managed.

SWVTC has written protocols for the handling of medications. Nursing personnel indicated that the facility fosters a teaching environment, which enables staff to feel comfortable in addressing any area where they might need additional instruction. Medication errors are reported and tracked both by the Director of Nursing and the Pharmacy and Therapeutics Committee.

Medication usage is monitored by the prescribing physicians for potential side effects and/or reactions. The medical staff stay informed about new medications by consistently reviewing the literature and guidelines. It was indicated that even though this is often a time-consuming process, it fosters a sense of confidence that their actions contain a reasonable expectation for having the greatest positive impact. Staff are appropriately trained in the use of medication management and must demonstrate competency before being able to administer the medications.

The medications are stored in a room under a double-lock. Medications are checked against the physician's order and the medication administration record before they are dispensed or administered.

7. There are mechanisms to address areas of concern regarding staff safety.

Interviews with administrative staff indicated that the facility does have a mechanism for addressing staff safety. There is an expectation at the facility that staff injuries are to be reported in a timely manner. The Human Resources Office tracks these and claims are filed, as appropriate.

The Safety/Health Committee addresses workplace safety. Issues addressed by this committee include staff injuries, the maintenance and safety of equipment used by staff in executing their duties, and campus-wide security issues. Environmental safety checks identify and correct physical conditions that would have an impact on the safety of both the staff and consumer.

The team was informed that the accident rates on the campus are very low. The highest injury rate is associated with the aggressive behavior of the residents.

FACILITY OPERATIONS / LIVING ENVIRONMENT

1. The residential units reflect personal choice and a home-like environment. Residents are afforded privacy.

There was evidence that the residents are provided with opportunities to personalize their rooms. In Cottage 5C, it was noted that several of the walls in each bedroom were painted a rich color like deep blue or green which gave rooms a comfortable inviting feel. Curtains or other window coverings were used to afford the residents privacy.

2. The residential environment is clean, odor free and well maintained.

Members of the OIG team conducted tours of selected residential units on campus, including Cottages 5C, 6B, 8C, the Pathways Cottage and a unit in Building 3. These buildings were noted to be clean, well maintained and odor-free. Furniture in the living areas appeared comfortable and well maintained. No broken or torn areas in the fabric were noted. Inviting colorful pictures/posters were on the walls. The use of stencils helped make the walls look less stark and institutional. Efforts to make these settings seem more home-like extended into the yard. Small patios with furniture, swings and hammocks were available for the residents' enjoyment.

The overall campus is very well maintained. The grounds had been recently mowed. Sidewalks and around the foundation of the buildings showed evidence of recent edging of the grass. Flowerbeds were generally well maintained. Play equipment was very well maintained.

A member of the review team had an opportunity to talk with several Building and Grounds staff and was impressed with their dedication and appreciation for the needs of the residents. All appeared to take real pride in the appearance of the campus and to understand the importance of assuring the safety of the residents.

The following capital improvement projects were identified as currently approved and funded:

- The replacement of roofing on all buildings, particularly those with shingled roofs
- The replacement of HVAC units on Buildings 1,2,9,10 and the cottages
- The replacement of the existing freezers/coolers and the construction of an additional freezer in Building 2 Food Service area.
- The replacement of the underground heat distribution lines

Administrative staff were asked to identify three of the most critical capital improvement projects that need to be addressed at the facility. Their response included:

- The renovation of the 14 cottages in order to provide better handicap access, storage, and activity space. These renovations include the replacement of the HVAC units.
- The construction of an enclosed area around the Building 3 patio.
- Obtaining an emergency generator to power the 14 cottages and Buildings 1,2,9, and 10

3. There is evidence that the residents are being taken care of by the facility.

Throughout the tours, the team had an opportunity to observe the residents. All appeared properly clothed, clean and well provided for by the facility. It was observed that staff promptly addressed any hygiene problems as they occurred.

The staff were observed treating the residents with dignity and respect. The manner in which staff interacted with the residents was supportive, positive and warm. The residents seemed happy.

In the Pathways Cottage, staff introduced the residents and included them in the conversation, when appropriate. Staff and resident interactions were relaxed, good-humored and respectful. Staff reported how proud they felt of the residents and the strides they had made. It was apparent by the residents' reactions that these comments were meaningful to them.

4. The facility provides for access to primary health care that is coordinated and comprehensive.

On the day of the inspection, there were 217 residents. SWVTC's medical director is the facility's primary care physician. The facility also has a family nurse practitioner and a psychiatrist. All residents received a comprehensive annual physical. The facility maintains an infirmary that serves residents with routine medical conditions that need closer monitoring. The facility has an on-call system for addressing medical concerns after 5:00 pm. Nursing personnel indicated that there is an excellent on-call physician response time to the calls, usually less than five minutes. Interviews revealed that nurses are empowered to initiate appropriate interventions for the residents in emergency situations.

The medical director maintains a good working relationship with the local hospital. This fosters a trust between the facility and the community provider that facilitates the residents receiving timely community-based healthcare. Residents have access to a number of other services such as dental, ophthalmology, and neurology.

Nursing staff complete quarterly healthcare reviews on all of the residents, noting any changes in their healthcare status and other significant information regarding their physical health.

5. The facility has a mechanism for accountability of resident's money.

Interviews with staff indicated that the facility has an established procedure for the accountability of resident's money. Staff that assist the residents in making the necessary purchases are required to submit a receipt.

FACILITY OPERATIONS / STAFFING PATTERNS

1. The facility maintains sufficient qualified staff to address the supervision and treatment needs of the residents.

Interviews were conducted with administrative and direct care staff. All those interviewed related that the facility maintains a sufficiently qualified staff to address the supervision and safety needs of the residents. Both management and clinical staff

indicated that it is often challenging for the facility to maintain adequate professional staff to assure the training needs of the residents. For example, the facility has been recruiting for a licensed physical therapy assistant and 2 RNs for approximately three months. One explanation offered was that the facility is not able to offer a competitive salary in many of these positions.

Many of the recent applicants for direct care staff positions are individuals who were displaced by the loss of manufacturing positions in the area. For the most part, interviews indicated that these individuals make excellent employees because of their good work ethic and willingness to participate in the training necessary to obtain the skills needed to effectively complete their duties. All those interviewed indicated that the average salary for the direct care staff should be increased in order for the facility to maintain an adequate workforce.

Staffing patterns in the residential areas included the following:

- In the cottages there were 2 direct services associates (DSA) during the day shift for the 8-10 residents, 1 DSA and 1 active treatment supervisor on the 2nd shift and 1 DSA on the 3rd shift
- In one of the units in Building 3, there were 4 staff members present for 18 residents.

2. Direct care staff turnover, position vacancies, and other forms of absenteeism are low enough to maintain continuity of resident supports and care.

Interviews indicated that the turnover rate for the facility is relatively low, currently around 6%. SWVTC has the lowest rate of turnover for all of the training centers, however, the facility has experienced an increase in turnover for the past several years.

Overtime usage at the facility continues to be an issue, but the facility has made some significant reduction in this since 2002. One of the contributing factors to the use of overtime is the Virginia Disability and Sickness Program, which enables persons on probation to go out on short-term disability. At the time of the inspection, there were 15 people out. The average length of absence from the facility as a result of the short term disability program, is 55 days. Interviews with direct care staff indicated that the most frustrating issue for them is their inability to take off accrued leave. Five of those interviewed reported having an excessive number of accrued hours. They have difficulty obtaining approval for vacation time because there is not enough staff to provide adequate coverage if the time is taken. This was also identified as a significant problem by administrative staff.

3. Direct care staff possesses the competencies necessary for providing services.

Interviews with training and supervisory staff as well as a review of the training materials revealed that the majority of critical tasks for direct care staff are based on competency reviews, which involved either tests or demonstrations. Staff have the ability to participate in a number of training opportunities.

Interviews with direct care staff revealed that they believe the facility provides them with the training necessary to feel confident in performing their duties.

FACILITY OPERATIONS / SYSTEM PERFORMANCE

1. The facility promotes effective and efficient services through data collection. Data collection is used to enhance facility performance.

Data collection is used to support and enhance facility performance in a number of areas. Staff training data is maintained to assure that staff have completed the training necessary for fulfilling their duties.

Data collection is central to the work of both the quality assurance office and risk management at the facility. Both review critical indicators regarding the safety and treatment needs of the residents. This information, more importantly, is routinely used to develop performance improvement initiatives. One project mentioned involved the facility changing the way they purchase laundry detergent. Instead of it being purchased in packaged containers as in most households, they began purchasing it in bulk. The savings involved in making this switch allowed for the purchase of new laundry equipment. In addition, a work opportunity was developed for residents who could now divide the detergent into individual containers for use in the residential areas. They could also be paid for delivering the containers to the appropriate units. This one initiative had multiple benefits.

2. There is a system for continuous quality improvement.

Interviews with administrative staff and a review of the facility's quality management plan revealed that SWVTC has a system for continuous quality improvement. Interviews revealed that the facility has initiated a number of successful quality improvement projects designed specifically to enhance the quality of services for the residents. The facility monitors a number of quality indicators such as the number of hours residents are involved in work, the number of IHP meetings in which the resident and family attended, and whether residents are engaged in appropriate social activity.

3. Consumers and other stakeholders have an active role in program development and quality improvement activities.

Interviews revealed that families have not been formally involved in program development and quality improvement activities within the facility. It was indicated however that the facility has a very active parents organization that provides feedback regularly.

FACILITY OPERATIONS / COMMUNITY RELATIONSHIPS

1. The facility has a strategy for developing and maintaining working relationships with other agencies and providers in its catchment area.

The facility is engaged in a number of activities that are designed to develop and maintain working relationships with community providers and other agencies. The facility director has been actively involved in the regional planning partnership, which has been meeting to define the needs of the region. One of the outgrowths of his participation has been the development of the Pathways Program on campus. As noted previously, the social workers and the medical director maintain regular contact with their counterparts in the community. The facility works with a number of volunteer organizations, churches and other groups that are very supportive of the work done by the facility.

The facility director has been providing leadership to staff on all levels regarding the importance of SWVTC maintaining a partnership with the community. His commitment to this is evident from the interviews with staff.

2. The facility has taken steps to understand and complete satisfaction surveys with external stakeholders:

a. With Community Services Boards

Even though no formalized surveys have been conducted with the CSBs, the facility has several mechanisms in place for receiving feedback.

b. With parents and/or legally authorized representatives

The facility has been doing parents satisfaction surveys for years. They did not do one last year because this was being completed by DMHMRSAS. Interviews indicated that the facility was not provided with feedback on the results of this survey by central office. Those interviewed indicated that the facility values the comments of family. It was stated that the parents' organization is very active and often provides valuable feedback to the facility.

c. With the DMHMRSAS Central Office

Although interviews indicated that there was not a formal mechanism established with Central Office management for obtaining feedback regarding the facilities performance, staff outlined several ways in which the facility is able to interface with the Central Office. These include the facility directors meetings, the medical directors meetings, and involvement with the Office of Risk Management. It was reported that the Commissioner has communicated his vision and goals for the system. It was also reported that the Office of Mental Retardation Services has been helpful.

Those interviewed indicated that the facility would appreciate more feedback from Central Office particularly regarding the data and other information that are routinely requested and provided.

3. The facility management and direct care staff have a working understanding about the capacity of the community to provide services. The facility has a clear understanding of its role within the community system.

Ten staff members were asked about this quality statement, including administrative, clinical and direct care staff. Those interviewed indicated that the facility has provided a vital service to the community through its thirty-year commitment to the provision of comprehensive residential, training and healthcare services to persons with mental retardation.

Staff at SWVTC voiced a belief that the facility is working in partnership with community providers to address the challenging and changing needs of this special population. This was best exemplified by the Pathways Program, which is designed to provide residential and training programs for persons from the region who are dually diagnosed. Staff in that program have experienced persons with very challenging behaviors be able to return to the community with increased skills in a relatively short period of time. This experience, as reported by several direct care staff, has broadened their beliefs that many more residents at the facility are capable of successfully residing in the community with the necessary supports. This service uses person centered planning as the framework for developing goals and strategies with the residents. Person centered planning is predicated on the belief that the person needs to be a full and respected participant in any decisions that impact his/her life. Staff in this program have had the benefit of experiencing first hand how this process works. Many indicated that it helped change their understanding of the capacity of the community to serve the same residents but at a different phase in their development.

4. The facility has the capacity for providing respite services for those age groups not normally served by the facility.

Interviews revealed that SWVTC makes every effort to provide respite services when requested. It was indicated that there were often emergency requests. Respite care is designed as a program of temporary care, 21 days or less, which is needed because of a "medical or other urgent conditions of the caretaking person(s) or as a means of providing the caretaking person(s) with a needed break" (SWVTC Instruction 410). It was reported that the facility had 12 requests for respite services during the period of July 1, 2003 through July 1, 2004 and the facility was able to accommodate all of them.

FINDINGS AND RECOMMENDATIONS

Finding 1: Space for vocational programming and other non-residential unit activities is not adequate.

Recommendation: It is recommended that DMHMRSAS place the highest priority on adding additional facility space for vocational programming and other non-residential unit activities.